St. Paul Lutheran Church S.H.I.N.E. Special Needs Health Profile and Emergency Contact Information

Child's Name: _____ Birth Date: _____

Parent/Guardian Name: _____ Relationship: _____ Phone: _____

Parent/Guardian Name: _____ Relationship: _____ Phone: _____

Emergency Contact: I give permission to release my child into the custody of:

Name _____ Relationship: _____ Phone: _____

Name _____ Relationship: _____ Phone: _____

Name _____ Relationship: _____ Phone: _____

Name _____ Relationship: _____ Phone: _____

Getting to know your child and his/her medical history is helpful in understanding the needs of your child while you are in church. Please complete section 1 through 8 below, as well as the attached seizure form if applicable.

1. Medical History

My child has been diagnosed by a physician with the following medical conditions which the S.H.I.N.E. staff should be aware:

☐ None ☐ Hearing Impaired ☐ Non-Verbal ☐ Tracheostomy

☐ Asthma ☐ Heart condition ☐ Panhypopituitarism ☐***Seizures

☐ Diabetes ☐ Hemophiliac ☐ Visually Impaired ☐ Shunt

☐ Gastrostomy tube ☐ Temperature sensitive ☐ Chronic Respiratory Condition

☐ Implantable Device *(Circle one: VNS, Baclofen pump, cardiac pacemaker)*

☐ Other Health/Medical Conditions *(attach separate sheet if needed)* _____

_____

_____

****If seizures are checked complete seizure questionnaire form also (see below)*

My child has the following physical restrictions: *(Please attach a separate sheet if needed.)* _____

_____

_____

Child's Name: _____ Birth Date: _____

2. Allergies: ☐ Yes ☐ No *(if yes, complete applicable information below)*

☐ Seasonal ☐ Peanut Allergy ☐ Tree Nut Allergy ☐ Bee Allergy ☐ Latex Allergy

☐ Food Allergy: _____

☐ Medication Allergy: _____

Allergy Details *(explain reaction to allergen)*: _____

_____

_____

_____

3. My child has Emergency Medication/Treatment as needed for:

☐ Seizures ☐ Allergies ☐ Asthma ☐ Diabetes ☐ Other: _____ ☐ None

If my child requires emergency medication/procedures while at church I understand it is my or my designated guardian responsibility to administer this.

List the name of emergency medication/treatment: _____

_____

4. Is there any special adaptive equipment or safety equipment that your child needs while in the classroom? *(For example wheelchair, walker, helmet.)*

_____

5. Physician Name: _____ **Phone Number:** _____

6. Medication: *My child takes the following medications...*

Name of Medication	**Dosage**	**Times per day**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's Name: _____ Birth Date: _____

7. Special behavior management:

Please describe any behavior issues that may occur while in the classroom. _____

_____

_____

Describe any special interventions that may help control these behaviors ? _____

_____

_____

Please describe any triggers that may result in behaviors. _____

_____

_____

Is any special training required for those working with your child in the classroom? _____

_____

_____

8. Medical and Liability Release Statements:

As the parent or custodial adult of _____, I give permission for St. Paul Lutheran Church, its agents, staff, and volunteers to obtain urgent or emergency care for my child, and I authorize health care providers to render such care as may be necessary. It is understood that reasonable efforts will be made to contact me prior to obtaining such care, but I authorize such care whether I am contacted or not, and I agree to be financially responsible for such care.

I give permission for my child to participate in the activities of Shine Ministry at St. Paul Lutheran Church. In consideration of the opportunity of my child to participate in the activities of St. Paul Lutheran Church, I release St. Paul Lutheran Church, its officers, agents, employees, staff and volunteers from any and all liability of any kind whatsoever for any loss or injury to my child arising from my child's participation; and I agree to indemnify and hold forever harmless St. PaulLutheran Church, its officers, agents, employees, staff, and volunteers from any and all liability of any kind whatsoever for loss or injury to my child arising from activities on the premises of St. Paul Lutheran Church.

Parent/Guardian Signature _____ **Date** _____

IMPORTANT: ***If your child has a history of seizures, please fill out the St. Paul S.H.I.N.E. Seizure History form on the next page.***

Child's Name: _____ Birth Date: _____

St. Paul SHINE Seizure History form *(please check box if your child has NO HISTORY OF SEIZURES ☐)*

1. Age when seizure activity was first diagnosed: _____ Date of last seizure: _____

2. Does child experience any warning signs or behavioral changes before a seizure occurs: ☐ No ☐ Yes

If yes, describe: _____

Describe what happens during a seizure: _____

_____

Describe any triggers that may cause a seizure in your child _____

3. What is the average length of time the seizure will last: _____

4. How frequently does the seizure occur?: _____

5. Is there any particular time of day or night that a seizure is most likely to occur? ☐ No ☐ Yes

If yes when: _____

6. What is your child's reaction after having a seizure: _____

_____

7. What is the average length of time until your child can return to normal activity after a seizure: _____

_____

8. List emergency/rescue medications that are prescribed for your child below:

Name of Medication	Dosage	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's Name: _____ Birth Date: _____

9. List medication taken daily by your child to control seizure activity below:

Name of Medication	Dosage	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician.) _____

A seizure is generally considered an emergency when:

- ☐ **Convulsive Tonic Clonic seizures last longer than 5 minutes**
- ☐ **Student has repeated seizures without regaining consciousness**
- ☐ **Student is injured or has Diabetes**
- ☐ **Student has a first-time seizure**
- ☐ **Student has breathing difficulties**
- ☐ **Student has a seizure in water**

11. Has your child ever been seen for continuous seizures? ☐ **No** ☐ **Yes**

If yes please explain: _____

12. How often does your child see the doctor for this condition? _____

13. Name of physician treating your child's seizure condition: _____ **Phone** _____

14. List any other concerns that the S.H.I.N.E. Staff should be aware of: _____

_____

15. Does your child have a Vagus nerve stimulator? ☐ **No** ☐ **Yes**

Parent/Guardian Signature: _____ **Date:** _____